County of Los Angeles - Department of Mental Health
Office of the Medical Director
Medi-Cal Professional Services and Authorization Division

Provider Relations Unit

CODE #	MENTAL HEALTH FEE-FOR-SERVICE (MHFFS) EDIT/DENIAL CODES
1	PROVIDER NUMBER IS MISSING OR INVALID
2	RECIPIENT NUMBER IS MISSING OR INVALID
3	SEX CODE IS MISSING OR INVALID
4	PRIOR AUTHORIZATION NUMBER IS INVALID
5	DATE OF SERVICE IS MISSING OR INVALID
6	PRIMARY DIAGNOSIS CODE IS MISSING OR INVALID
7	PLACE OF SERVICE IS MISSING OR INVALID
8	QUANTITY IS MISSING OR INVALID
9	PROCEDURE CODE IS MISSING OR INVALID
10	THE BEGIN SERVICE DATE DOES NOT MATCH THE END SERVICE DATE; BLOCK BILLING IS NOT ALLOWED
11	LA CO RECIPIENT MIS NUMBER IS MISSING OR INVALID
12	PROVIDER SIGNATURE IS MISSING OR CLAIM IS NOT AN ORIGINAL
13	HOSPITAL PRIOR AUTHORIZATION NUMBER IS INVALID
15	LINE AMOUNT (CHARGES) IS MISSING
16	CLAIM RECEIVED AFTER THE SIX MONTH BILLING LIMITATION
17	FORMER CCN ON ADJUSTMENT IS INVALID
18	DATE OF SERVICE IS GREATER THAN THE JULIAN DATE OF CCN
19	CLAIM RECEIVED AFTER THE ONE YEAR BILLING LIMITATION FOR CLAIM WITH A LATE BILLING INDICATOR
20	LINE AMOUNT (CHARGES) IS INVALID (LESS THAN $10.00)
100	BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE
101	BILLING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
102	BILLING PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
103	RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE
104	RENDERING PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
105	RENDERING PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
106	RENDERING PROVIDER TYPE IS NOT RELATED TO THE BILLING GROUP PROVIDER TYPE
107	RENDERING/STAFF PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE
108	RENDERING/STAFF PROVIDER NUMBER IS NOT FOUND ON THE LA CO PROVIDER FILE FOR DATE OF SERVICE
109	RENDERING/STAFF PROVIDER STATUS ON THE LA CO PROVIDER FILE IS INVALID FOR DATE OF SERVICE
110	RENDERING/STAFF PROVIDER IS NOT REGISTERED TO PROVIDE SERVICES WITH THIS BILLING PROVIDER
111	PLACE OF SERVICE IS NOT VALID FOR THE PROVIDER TYPE
200	RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE
201	RECIPIENT IS NOT ELIGIBLE ON DATE OF SERVICE
202	RECIPIENT MIS NUMBER ON CLAIM DOES NOT MATCH THE MIS NUMBER ON THE LA CO MIS FILE
203	RECIPIENT HAS A NON-FEDERAL AID CODE AND IS NOT ELIGIBLE FOR SERVICES
204	RECIPIENT HAS MEDICARE COVERAGE ON DATE OF SERVICE
205	RECIPIENT NUMBER IS NOT FOUND ON THE MEDS ELIGIBILITY FILE - RECIPIENT NUMBER WAS FOUND ON THE LA CO MIS FILE
206	RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER

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207	RECIPIENT NOT ELIGIBLE FOR LACMH BENEFITS UNTIL VALID PAYMENT/DENIAL INFORMATION IS GIVEN FROM OHC CARRIER
300	PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE
301	PROCEDURE CODE IS NOT FOUND ON THE LA CO PROCEDURE FILE FOR DATE OF SERVICE
302	THE PROVIDER OF THIS SERVICE IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
303	PROCEDURE CODE IS INVALID FOR AGE OF RECIPIENT; JUSTIFICATION REQUIRED
304	PROCEDURE CODE REQUIRES AN LA CO PRIOR AUTHORIZATION NUMBER
305	PROCEDURE CODE IS AN INVALID ORGANIZATIONAL PROVIDER SERVICE
306	RENDERING/STAFF PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
307	RENDERING PROVIDER IS NOT ELIGIBLE FOR THE TYPE OF SERVICES BILLED
308	PROCEDURE CODES 99222 AND 99232 CANNOT BE BILLED WITH A PLACE OF SERVICE 22
309	AN ORGANIZATIONAL PROVIDER PROCEDURE CODE BILLED ON OR AFTER SEPT. 1. 2000 WAS USING THE OLD RATE
400	PRIMARY DIAGNOSIS CODE IS NOT FOUND ON THE LA CO DIAGNOSIS FILE
401	PRIMARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT
402	SECONDARY DIAGNOSIS CODE IS NOT FOUND ON THE LA CO DIAGNOSIS FILE
403	SECONDARY DIAGNOSIS CODE IS INVALID FOR AGE OF RECIPIENT
500	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE
501	RECIPIENT NUMBER ON THE CLAIM DOES NOT MATCH THE RECIPIENT NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE
502	PROVIDER NUMBER ON THE CLAIM DOES NOT MATCH THE PROVIDER NUMBER ON THE LA CO PRIOR AUTHORIZATION FILE
503	PROCEDURE CODE ON THE CLAIM DOES NOT MATCH THE PROCEDURE CODE ON THE LA CO PRIOR AUTHORIZATION FILE
504	DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO PRIOR AUTHORIZATION FILE
505	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE - THE CLAIM WILL RECYCLE
520	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
521	DATE OF SERVICE ON THE CLAIM DOES NOT MATCH THE DATE OF SERVICE ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
522	DATE OF SERVICE IS DENIED ON THE LA CO HOSPITAL PRIOR AUTHORIZATION FILE
531	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 9 MORE WEEKS
532	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 8 MORE WEEKS
533	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 7 MORE WEEKS
534	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 6 MORE WEEKS
535	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 5 MORE WEEKS
536	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 4 MORE WEEKS
537	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 3 MORE WEEKS
538	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE UP TO 2 MORE WEEKS
539	HOSPITAL PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO HPA FILE - THE CLAIM WILL RECYCLE ONE MORE WEEK
600	MEDI-CAL FEE-FOR-SERVICE CLAIM IS NOT PAYABLE BY LA CO LMHP
601	EMERGENCY CLAIM REQUIRES A PROCEDURE CODE OF 99284 OR X9502 OR X9500 WHEN USING POS 23
602	EMERGENCY CLAIM REQUIRES AN 'Y' IN THE EMERGENCY CLAIM INDICATOR FIELD WHEN USING POS 23 FOR PC 99284 OR X9500 OR X9502
603	NO NAME BECAUSE OF NO ELIGIBILITY. EXAMINER WILL ENTER THENAME FROM THE CLAIM.
700	NO HISTORY WAS FOUND FOR THIS ADJUSTMENT
701	THE ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT
702	THIS IS AN EXACT DUPLICATE OF A PREVIOUS CLAIM
703	THIS IS A POSSIBLE DUPLICATE OF A PREVIOUS CLAIM
704	PRIOR AUTHORIZATION NUMBER IS NOT FOUND ON THE LA CO PRIOR AUTHORIZATION FILE
705	THE PROCEDURE CODE BILLED EXCEEDS THE OCCURRENCES APPROVED ON THE LA CO PRIOR AUTHORIZATION FILE
706	DISCHARGE SUMMARY IS NOT PAYABLE WHEN BILLED WITH A HOSPITAL VISIT

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707	HOSPITAL VISIT IS NOT PAYABLE WHEN BILLED WITH A DISCHARGE SUMMARY
708	SELECTED PSYCHIATRIC SERVICES LIMITED TO 8 VISITS IN A 4 MONTH TRIMESTER WITHOUT AN APPROVED LA CO PRIOR AUTHORIZATION
710	ONLY ONE SERVICE IS ALLOWED PER DAY DURING AN INPATIENT HOSPITAL STAY FOLLOWING THE DAY OF ADMISSION
803	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH A 103 OR 204) FROM 11-15-99 TO 1-7-00
804	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED (WITH AN 011 OR 202) FROM 11-15-99 TO 2-1-00
805	THIS CLAIM REPROCESSES A CLAIM WITH A VALID HPA NUMBER THAT PREVIOUSLY RECEIVED A 520 DENIAL
806	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 305 DENIAL
807	THIS CLAIM REPROCESSES A CLAIM BILLED FOR MULTIPLE UNITS BUT PAID FOR A QUANTITY OF ONE
808	THIS CLAIM REPROCESSES A CLAIM WITH A 90811 PROCEDURE CODE THAT PREVIOUSLY RECEIVED A 301 DENIAL FROM 1-17-00 TO 4-21-00
809	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 303 DENIAL FROM 11-15-99 TO 5-1-00
810	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY DENIED WITH A 200. 201. OR 205 DENIAL FROM 2-1-02 TO 4-19-02
811	THIS CLAIM REPROCESSES A CLAIM PREVIOUSLY PAID TO A RENDERING PROVIDER FROM 7-1-02 TO 9-30-02
901	PROCESSED AMOUNT ADJUSTED TO MAXIMUM ALLOWABLE
902	QUANTITY BILLED EXCEEDED MAXIMUM ALLOWED BY LA COUNTY MENTAL HEALTH; PROCESSED AMT ADJUSTED TO MAXIMUM QUANTITY ALLOWED
906	PAYMENT REDUCED BECAUSE OF OTHER INSURANCE PAYMENT
908	PAYMENT REDUCED BECAUSE OF PATIENT LIABILITY (SHARE OF COST)
971	LA COUNTY MENTAL HEALTH PAYMENT VOID
972	LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN OVERPAYMENT
973	LA COUNTY MENTAL HEALTH PROVIDER INITIATED ADJUSTMENT AS A RESULT OF AN UNDERPAYMENT
974	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT BILLING PROVIDER
975	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT RENDERING PROVIDER
976	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT PROCEDURE CODE
977	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT DATE OF SERVICE
978	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT MEDS ID
979	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT AMOUNT PAID
980	LA COUNTY MENTAL HEALTH INITIATED ADJUSTMENT TO CORRECT QUANTITY

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FEE-FOR-SERVICE NETWORK PROVIDERS DENIAL REASONS CHEAT SHEET
Revised - January 9, 2008

DENIAL REASONS	RULE #	DENIAL DESCRIPTION	DESCRIPTION/RESOLUTION
Verify FFS Medi-Cal Payer	Inb837.Post.31	Medi-Cal was not sent as the payer.	FFS Network Provider must ensure that on the "Payer" tab "Medi-Cal" is selected with a check mark. If not, proceed to check it and enter the EVC number from the Medi-Cal eligibility response. There should be 2 green checks in the workspace on the Client Tab. Additionally, there should be no open circle or red "X" in the "M" (Medi-Cal) column. If there is an open circle or red "X" in the "M" column, then according to the State Medi-Cal Eligibility Determination System (MEDS) there is no eligiblity for the client (check for typographical error in the client index number [CIN] and perform a new eligibility check. Ensure Medi-Cal is selected with a check mark and 2 green checks appear in the workspace on the Client Tab) and FFS Network Provider will need to work with client and/or Department of Social Services to obtain eligibility.
Client ineligible for service	Eligibility Check	Client is not enrolled and/or DMH Client I.D. # is invalid or not eligible for services.	FFS Network Provider must verify that client is eligible (ensure there was no typographical error in CIN # and if so perform a new eligibility check and submit a new claim) for service with Medi-Cal and/or Medicare. Perform a new eligibility check ensuring that there are two green checks in both "D" and "M" columns. Click on the green check in the "D" column and select "Update Enrollment" or "Enroll Client." Enter requested data in the data fields. Proceed to enter a new claim.

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DENIAL REASONS	RULE #	DENIAL DESCRIPTION	DESCRIPTION/RESOLUTION
Verify FFS Procedure & Service Time	Inb837.Post.33	Procedure code and/or service time is incorrect.	FFS Network Provider must verify that the procedure code is correct for client (i.e., age, service time etc.). The procedure code service time must be reflected in minutes and not units, i.e., the "service unit amount" is within the appropriate range of the published guidelines (refer to the Guide to Procedure Codes for Claiming Specialty Mental Health Services: http://dmh.lacounty.info/hipaa/downloads/PROCEDURE_CODES_MANUAL.pdf). The FFS Network Provider must claim with procedure codes/services applicable to their specific taxonomy. If all of the above was performed and denials continue to occur, notify the Provider Relations Unit at (213) 738-3311 so they may research the denial to determine the problem. The Provider Relations Unit's troubleshooting efforts may include: (1) Verifying whether the Provider's IS and/or license/contract record(s) may be expired. (2) Verifying whether the Provider's taxonomy is expired. (3) Verify whether the Provider's IS records are missing taxonomy or other procedure code conversion data.
Verify Diagnosis Code	Inb837.Post.37	Diagnosis code is incorrect or not valid	FFS Network Provider must verify that the diagnosis code was valid (minus typographical errors), payable by the Local Mental Health Plan and is the appropriate code to be used with the procedure code and service time. The HIPAA-compliant ICD 9 diagnosis codes to be used in the Integrated System may be downloaded from the following website address: http://dmh.lacounty.info/hipaa/downloads/IS_DIAG_CODES_TABLE_FOR_FFS.pdf.
Check for Dup claim	Inb837.Post.4	Duplicate claims were submitted in EDI/SFT (not DDE) transmission.	This denial affects EDI/SFT (Electronic Data Interchange) users. This error should not occur with DDE (Direct Data Entry) users (those who access the IS system via webpage). Ensure that the patient account number (2300_CLM01) is unique across all claims submitted by a single EDI/SFT submitter/sender.

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DENIAL REASONS	RULE #	DENIAL DESCRIPTION	DESCRIPTION/RESOLUTION
Verify Procedure Code	Inb837.Post.27	Procedure code is not valid in IS	FFS Network Provider must ensure that the procedure code exists in the IS repository. (Refer to the Guide to Procedure Codes for Claiming Specialty Mental Health Services: http://dmh.lacounty.info/hipaa/downloads/PROCEDURE_CODES_MANUAL.pdf). If the appropriate procedure code was used and this denial continues to occur, notify the Provider Relations Unit so they may further research the denial. Reasons why denials may need to be researched by the Provider Relations Unit are as follows: (1) The Provider's IS and/or licensing/contract record(s) may be expired. (2) The Provider's taxonomy may not be appropriate for the service. (3) The Provider's IS record may be expired, missing taxonomy or other procedure code conversion data.
Verify Billing and Pay To Prov	Inb837.Post.7	IS Billing and/or Pay to Provider is not in the IS and/or FFS Network Provider is not active on the service date.	There must always be a Billing Provider on the transaction. This provider must exist in the IS and be active on the service date of the claim. This provider must be authorized in the IS to be a billing provider. There may also be a Pay-To-Provider, which has to be authorized in the IS. (For SFT/EDI submitters, double check that Billing and Pay-To-Providers' IDs are correct). Contact the Providers Relations Unit if futher assistance is needed.
Verify FFS delay reason code	Inb837.Post.35	The service date on the claim was more than 6 months from the date the service was rendered and a delay reason code was missing or not valid for the FFS Network Provider.	Refer to the IS Codes Manual to obtain the latest version of the Late Codes (Delay Codes [page 840]) at the following website address: http://dmh.lacounty.info/hipaa/downloads/IS_CODES_MANUAL.pdf.
Verify FFS 2 Rendering Provider Taxonomy	Inb837.Post.29	Providers discipline (i.e., MD, Phd, MFT) is incorrect or more than 1 taxonomy was used.	Contact the Providers Relations Unit, as staff will need to proceed as follows: (1) The Provider's IS license/contract record(s) may be expired and may need to be updated. (2) The Provider's taxonomy may be invalid. (3) The Provider's IS record may be expired, missing taxonomy or other procedure code conversion data. The Provider Relations Unit must update the providers' records and ensure that there is only one entry for the taxonomy.

FEE-FOR-SERVICE NETWORK PROVIDERS DENIAL REASONS CHEAT SHEET
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DENIAL REASONS	RULE #	DENIAL DESCRIPTION	DESCRIPTION/RESOLUTION
Verify Single Service	Inb837.Post.25	More than 1 service was entered on the claim line.	Verify that there is only 1 service line per claim. If not, enter one service line per claim and re-enter a new claim. This denial pertains more to SFT/EDI users. This error should not occur with DDE users.
Verify Medi-Cal Medicare ID	Inb837.Post.39	Medi-Cal or Medicare ID is incorrect.	If Medi-Cal is specified as a payer, ensure that the clients Medi-Cal ID is in the CIN format - 8 digits and a letter (e.g. 12345678A). If Medicare is specified as a payer ensure the client's Medicare ID is in the format with a minimum of 9-digits and a max of 12-digits (e.g. A12345678XYZA).
Reject Corrected and Replacemt	Inb837.Post.2	Corrected and/or replacement claims were rejected.	The IS will process only one (1) original or eight (8) voided claims. This error message will be received when the re-submit button in the Claim Tab has been selected. It is recommended these claims be re-entered as if they were brand new.
Verify Medicare and Insurance	Inb837.Post.17	No amount paid was entered.	These providers submit claims to Medicare and other insurance before submitting the claim to DMH. Therefore, if Medicare or other insurance are referenced as payers, there must be an amount paid, even if it is $0.00. In cases where Medicare is referenced as a payer, if the amount paid loop exists, the paid amount should equal to $0.00. If other insurance is referenced as payer, IS will reject the claim.
Prev Resub Status For Resub	Inb837.Post.5c	The "Resubmit" button was selected for a claim that was never denied.	Resubmitted claims must have original claims that have already been denied. Ensure all resubmitted claims reference the original (initial) claims and that the original (initial) claims have been denied.
Verify Late Claims for Delay reason code	Inb837.Post.19	There was no delay reason code submitted in the electronic claim or it was invalid.	Claims filed more than 6 months **after** the service date, **must** include an appropriate delay reason (late) code. Refer to the IS Codes Manual to obtain the latest version of the Late Codes (Delay Codes at the following website address: http://dmh.lacounty.info/hipaa/downloads/IS_CODES_MANUAL.pdf.
Verify Service Date to Current Date	Inb837.Post.28	Service date is more than 1 yr before the current date.	The service date was submitted with a date that was more than 1 year before the current date of submitting the claim and the claim was rejected. Dates of service more than 1 year from the date a service was rendered or submitted in the IS will be rejected.
Verify Subscriber Enrollment	Inb837.Post.10	Subscriber ID # is invalid and/or Subscriber is not enrolled w/ DMH.	Verify the subscriber is enrolled with DMH. Ensure that the subscriber ID is valid.

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Prior ClaimID For Void/Resub	Inb837.Post.5a		In order to void a claim, the original claim must be in the system with a status other than submitted or denied. If the original claim was not accepted into the system, then a void transaction is not valid. In order to re-submit a claim, the prior claim must have been accepted and either voided or denied. Ensure that the original claim has been processed properly and is in the appropriate state to perform the VOID or Resub.
NULL			Could be an unhandled exception. Need to view on a case by case basis. This could also be from system issues. Contact the Provider Relations Unit at (213) 738-3311 to assist with further research.
Verify Payer	Inb837.Post.11	Payer is invalid not w/DMH.	In EDI/SFT claims, verify that the payer referenced on the inbound claim is DMH. Identification information must consist of: Payer Name, Id Qualifier and Payer Primary Identifier. This denial pertains to SFT/EDI users. This error should not occur with DDE users.
Verify Submitter	Inb837.Post.3	Submitter's last name or org. name invalid and/or Submitter ID is invalid or not active.	Submitter's last name/organization name and the submitter identifier must be found in the IS database. The submitter must also be active on the date of service. This denial pertains to SFT/EDI users. This should not occur with DDE users.
Original/Resub Status For Void	Inb837.Post.5b	A denied claim cannot be Voided.	If there is only 1 original claim it must not be denied before submitting a void. If there is an original and one or more submitted claims, the last resubmitted claim **cannot** be denied and all the others **must have been denied,** including the original, before submitting a void.
Verify Insurance Type Code	Inb837.Post.49	Insurance type code is invalid for Medi-Cal, Medi-care or Private insurance.	Verify that the Insurance type code for Medi-Cal, Medicare or Private insurance is valid. If the insurance type is Medi-Cal, it should be 'MC' and if it is Medicare it should be 'MB.' Typically the insurance type is set to 'CI'. If the payer is not Medi-Cal or Medicare it is assumed to be private insurance. This denial pertains more to SFT/EDI user. This should not occur with DDE users. Contact the EDI/SFT Technical Support Group if more details are needed.
Verify service date to date of Death	Inb837.Post.15	Client service date and Death dates are not valid.	This error occurs because multiple client ID's exist, and one is terminated. Contact the Providers Relations Unit at (213) 738-3311 to be directed to "Find Client" feature in the IS to locate the client's correct DMH Client ID.

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Verify FFS 2 Plan	Inb837.Post.30	FFS plan code was invalid.	Verify that the MCF plan code is correct. The correct plan code is 1001. This pertains to SFT/EDI users. This error should not occur with DDE users. (2330A_REF02=1001). Contact the EDI/SFT Technical Support Group at (213) 251-6618 if more details are needed.
Verify Time Limits	Inb837.Post.16	Service cannot exceed more than 24 hours.	FFS Netork Provider must ensure the service time does not exceed more than 24 hours. (no more than 1440 minutes).
Verify Receiver	Inb837.Post.6	Receiver code is invalid.	The receiver of all claims **must** be DMH. DMH receiver ID should be valid and used. See Companion Guide: http://dmh.lacounty.info/hipaa/ffs_SecureFile.htm. This error pertains to SFT/EDI users and should not occur with DDE users. Contact the EDI/SFT Technical Support Group at (213) 251-6618 if more details are needed.
Validate Client has not been cross referenced	Inb837.Post.48	Client ID has been crossed with another person ID #.	Verify the subscriber ID is a valid person's record that has not been cross referenced with another person's id. This function needs to be addressed by DMH support. FFS2 billers do not have access to the area of the IS that enables them to view the client cross-reference records. In order to verify this information, a Helpdesk associate (213-351-1335) needs to log in to the clinical application and view the details of the client in question.
Verify DateTime string w/Date Qualifer	Inb837.Post.51	Date not in yyyy/mm/dd format.	The date must be consistant with date qualifer and in the format of YYYYMMDD. This pertains to SFT/EDI users. This should not occur with DDE users. Contact the EDI/SFT Technical Support Group if more details are needed.
Verify Service Time	Inb837.Post.45	Service unit count was less than 1.	Verify and/or correct the service minutes to ensure there is not a zero (0) or a negative number entered.
Verify Void Claim	Inb837.Post.5	Original or resubmitted claim does not exist or is not found.	FFS Network Providers are to ensure that if the claim is voided or resubmitted, the voided claim has an original inbound claim previously submitted in the IS. In order to void a claim, the original claim must be in the system with a status other than submitted or denied. If the original claim was not accepted into the system, then a void transaction is not valid.